STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155729	B. WIN			08/07/2013
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
TAG F000000	This visit was for State Licensured Survey dates: 7, 2013.  Facility number: 2  Survey Team: Julie Call, RN and 7, 2013)  Virginia Tervee and 7, 2013)  Virginia Tervee and 7, 2013)  Sue Brooker, In Angela Strass,  Census bed type SNF/NF: 55  Total: 55  Census payor of Medicare: 2  Medicaid: 41  Other: 12  Total: 55  These deficient findings cited in IAC 16.2.	or a Recertification and e Survey.  August 1, 2, 5, 6, and  1: 002549 1: 155729 100289420  TC (August 1, 5, 6, er, RN (August 1, 5, 6, RN)  Per : type:	F00		Preparation and execution of the plan of correction does not constitute admission agreement by  provider to the truth of the fact alleged or the conclusions set forth in the Statement of Deficiencies  rendered by the reviewing agency. The Plan of  Correction is prepared and executed solely because it is required by the provisions federal and state law.  adams-Heritage maintains that the alleged deficiencies do not individually collectively jeopardize the health and/or the safety of its residents  nor are they of such character to limit the provider's capacity to render adequate resident care.  Furthermore, adams-Heritage asserts that it is in	his or s  of t or
	Quality review cor	npleted on August				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

002549

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155729	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 08/07/2013			
	PROVIDER OR SUPPLIEI HERITAGE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  12011 WHITTERN RD  MONROEVILLE, IN 46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		R LSC IDENTIFYING INFORMATION)		ceach corrective action should be cross-referenced to the appropriate substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of August 15, 2013.  Further, we request desk review (paper compliance) for compliance, if acceptable compliance and state regulations, and correlate with most recent contemplated accomplished corrective action. These do not necessarily chronologic correspond to the	e. d for ly			
				date that Adams Heritage is under the opinion that it				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED  08/07/2013			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD				
ADAMS I	HERITAGE		MONROEVILLE, IN 46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE			
				was in compliance with the requirements of				
				participation or that correcting action was necessary.	ve			

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Event ID: 3UZL11

Facility ID: 002549

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHI	DBIG	00	COMPL	ETED	
		155729	A. BUII			08/07/	08/07/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE			
ADAMOL	IEDITACE				WHITTERN RD			
ADAMS F	HERITAGE			MONK	DEVILLE, IN 46773			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F000279	483.20(d), 483.20	O(k)(1)						
SS=D	DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the							
		evelop, review and revise						
	the resident's comprehensive plan of care.							
	The facility must	develon a comprehensive						
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to							
	-	medical, nursing, and						
		nosocial needs that are						
	identified in the comprehensive assessment.							
	•	ist describe the services						
		nished to attain or maintain						
	-	hest practicable physical,						
		hosocial well-being as 183.25; and any services						
		vise be required under						
		not provided due to the						
		e of rights under §483.10,						
		t to refuse treatment under						
	§483.10(b)(4).							
	Based on inter-	view and record	F00	0279			08/09/2013	
		ility failed to initiate a			It is the policy of this provider t	to		
		aranoia for 1 resident			develop, review and			
	•	of 36 residents						
	` ,				revise residents' comprehensi	ve		
	reviewed for ca	are plans.			care plan based on			
					needs identified in			
	Findings includ	ie:			comprehensive assessment.			
	Review of the clinical record for							
	Resident #56 c	on 8/5/13 at 10:13 a.m.,						
	indicated the fo	ollowing: diagnoses			1. What corrective action will	<u>L</u>		
		vere not limited to, CHF			be accomplished for			
	(congestive heart failure), COPD (chronic obstructive pulmonary							
					those residents found to have	<u>re</u>		
	•				been affected by this			
	uisease), HTN	(hypertension),						

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Event ID: 3UZL11

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If continuation sheet Page 4 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00 COMPLI			TED
		155729	B. WIN		08/07/2013		2013
		<u> </u>	Б. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			WHITTERN RD		
ADAMS	HERITAGE				OEVILLE, IN 46773		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·	+	DATE
	diabetes mellit				alleged deficient practice?		
	depression, ar	id anxiety.					
	<b>, ,</b> , , , , ,	5 D : 1 4 #50					
		es for Resident #56,			A care plan for Paranoia was		
		indicated she was			completed for Resident		
		efusing to wear O2			#56 on August 8, 2013.		
	, , , ,	dered, stating "You are			#00 011 August 0, 2010.		
	poisoning me with this."  A Social Service Progress Note for Resident #56, dated 10/1/12,						
					2. How other residents havi	ing	
					the potential to be		
	indicated nursing documented on						
	9/29/13, she was refusing to wear her				affected by the same deficie	<u>ent</u>	
		she was being			practice will be		
	poisoned.				identified and what corrective	ve	
	polociiou.				action(s) will be taken?		
	A Behavior He	alth					
		valuation for Resident					
		3/12 and written by a			Other residents that could be		
		ndicated she was			affected by the same		
		evaluation and			ancolod by the dame		
		her thought process			deficient practice would be		
		e to periods of anxiety			identified as those with a		
		The evaluation also			diagnosis of Daranaia Nana	word	
	· -	nad begun to refuse			diagnosis of Paranoia. None v	were	
		ression from the			oo Moritinou.		
		cated her presentation					
		ination of psychomotor					
		nd paranoia about her			3. What measures will be pu	<u>ıt</u>	
		•			into place or what		
	care and surroundings plus cognitive loss. The impression from the				systemic changes will be me	ade	
	•				to ensure that the		
	evaluation also indicated a low dose						
		tipsychotic like			deficient practice does not		
	•	mg (milligrams) might			occur?		
	pe considered	to address the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155729	B. WIN			08/07/2	2013
			5. ,,11		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹			WHITTERN RD		
ADAMS	HERITAGE				DEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	paranoia and t	he belief staff were					
	poisoning her.						
					Social Service will conduct au	dits	
	A Social Servi	ce Progress Note for			on residents		
		dated 10/10/12,			who have had a behavioral		
	•	was anxious and voiced			evaluation and assure		
	people were laughing at her.						
					that if care plan changes were	,	
					necessary, they were		
	A Social Service Progress Note for Resident #56, dated 10/11/12,						
					made at that time.		
	indicated she continued to display paranoia and continued to remove her oxygen. The note also indicated						
					4. How the corrective action	(s)	
	she was obser	ved swearing at family			will be monitored to	157	
	and becoming	easily agitated.					
		, 0			ensure the deficient practice	<u>.</u>	
	A physician's o	order for Resident #56,			will not recur?		
		2, indicated Seoquel 50					
		HS (hour of sleep).					
	ling every day	i to (flour of sicep).			Information gathered from the		
	A Dobovior Cu	mmon, for Docident			audits will be		
		mmary for Resident					
	· ·	17/12, indicated she			forwarded to the QA committe	e	
		episodes of delusional			for recommendations		
		aranoia. The summary					
		she was receiving			and review monthly for two		
	Seroquel 50 m	g HS.			months, then quarterly		
					thereafter. QA committee will		
	Facility care pl	ans for Resident #56			recommend time		
	included the problem areas of: depression, potential side effects of taking anti-depressant medication,						
					frame for continued monitoring	g.	
		tial side effects of					
	, , ,	riety medication, and			<b>.</b>		
	_	•			5. By what date the systemic	<u>c</u>	
	•	effects of taking			changes will be		
	ı antı-dsvchotic	medication. There was	ı		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155729		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155729	B. WING		08/07/2013
	PROVIDER OR SUPPLIE HERITAGE	R	12011	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD OEVILLE, IN 46773	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	no facility care area of parance non-pharmace implemented to social Service interviewed or During the interviewed or her paranoi the developmentaining to be psychiatric diagiointly developmentaining to be psychiatric diagional Social Second Second Social Second Sec	ological interventions o address paranoia.  It staff #2 was a 8/6/13 at 11:34 a.m. erview she indicated she te any care plan for concerning the problem a. She also indicated ent of care plans rehaviors and gnoses were to be used between Nursing rvice.  Veloping care plans d on 8/6/13 at 4:00 p.m. nistrator and the rsing. A policy a development of care	TAG	completed? August 9, 2013.	DATE

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Facility ID: 002549

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PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155729			A. BUILDING B. WING	00	COMI	COMPLETED  08/07/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  12011 WHITTERN RD  MONROEVILLE, IN 46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE		

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Facility ID: 002549

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155729	B. WIN			08/07/	2013
	PROVIDER OR SUPPLIER HERITAGE	TATEMENT OF DEFICIENCIES	•	12011 V	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD DEVILLE, IN 46773		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	, The state of the	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services prov facility must be pr persons in accord written plan of car Based on interv review, the faci physician order completion of a	UALIFIED PERSONS/PER  rided or arranged by the rovided by qualified dance with each resident's	F00	00282	It is the policy of this provider tensure that residents with lab orders are scheduled per order indicated.	0	08/13/2013
	record began of a.m., indicated but were not lin vascular attack anemia, atrial f hypertension, of thrombocytope tremors and de The April 2013 physician order physician on 4-The April 2013 indicated labora metabolic pane	sident #5's clinical on 8-5-2013 at 10:23 diagnoses included nited to, cerebral a, speech disturbance, ibrillation, depression, nia, anxiety, dypnea, ehydration.  recapitulation of rs was signed by the e1-2013.  recapitulation atory orders for a basic el (BMP) and a licount (CBC) to be			1. What corrective action(s) is be accomplished for those residents found to have been affected by the alleged deficient practice?  Resident #5 labs (BMP & CBC are scheduled for every 3 months per order as or August 6, 2013.  2. How will other residents having the potential to be affected by the same deficient practice	r <u>e</u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155729	B. WIN			08/07/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹	12011 WHITTERN RD				
ADAMOI	IEDITACE						
ADAMS I	HERITAGE			MONRO	IROEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					be identified and what		
	A consultant pl	harmacist			corrective action(s) will		
	•						
	recommendation dated 2-14-2013, indicated Resident #5 had labs				be taken?		
	ordered every	3 months for a BMP					
	and CBC. The	consultant pharmacist					
	indicated last laboratory draws were				Other residents having the		
		t 2012 and since the			potential to be affected by		
	_	ff hospice to be sure					
		•			the same deficient practice wo	uld	
	the labs were o	compieted.			be identified as		
	A review of laboratory results in				those with lab recommendatio	20	
					from the consultant	115	
	Resident #5's	clinical record indicated			I form the consultant		
	a CBC and BM	IP were completed on			pharmacist. From April 2013 to	,	
		a BMP was completed			present, all pharmacy	<b>'</b>	
		There were no			process, an priaminally		
					recommendations were audite	d l	
		ilts for a CBC as			to assure that		
	ordered for Ma	y 2013.					
					all pharmacy recommendation	s	
	During an inter	view with the Director			have been addressed.		
	of Nursing (DC	N) on 8-6-2013 at 9:31					
		indicated the lab					
	· ·	CBC from the physician					
		for April 2013 were not			3. What measures will be pu	<u>t</u>	
		•			into place or what		
		laboratory book and			systemic changes will be ma	do	
	the CBC was r	not done.			to ensure that the	<u>de</u>	
					to ensure that the		
	During an inter	view with Licensed			deficient practice does not		
	Practical Nurse	e (LPN) #5 on 8-6-2013			recur?		
		PN #5 indicated the					
	Medical Records staff would write the						
		ers from the Physician			A system has been developed	to	
	•	on a calendar in the			assure the		
	laboratory bool	k and LPN #5 indicated					
	she prepared t	he laboratory request			recommendations are reviewe	d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155729				08/07/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
A D A M O I	IEDITA OE				WHITTERN RD		
ADAMS F	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	slips from the	calendar.			monthly.		
	During an inter	view with the Medical			Pharmacist's report will be ser	nt to	
	•	#6 on 8-7-2013 at 8:40			DON/Designee.		
				DON/Dasissas a suit distaile state			
	•	cal Records Staff #6			DON/Designee will distribute t recommendations	ne	
	indicated she did not receive a copy				recommendations		
		ant Pharmacist's			to the appropriate physician.		
	Medication Regimen Review dated 2-14-2013 which recommended labs				DON/Designee will		
for a CBC and BMP every 3 months					monitor/audit monthly for retur	n	
	for Resident #5. She indicated she				response and		
	did not know to place the CBC and						
	BMP on the lat	•			accuracy of order.		
		o calcildar.					
	Fundban intomic	our with the Medical					
		ew with the Medical			4. How the corrective action(s)		
		#6 on 8-7-2013 at 8:42			will be monitored	(3)	
	a.m, indicated	she was not			wiii be momtorea		
	responsible for	reviewing the			to ensure the deficient practi	ice	
	recapitulations	for lab orders to be			will not recur?		
	placed on the I	ab calendar. She					
	•	acility did not have a					
		e to double check the					
		to be sure lab orders			Result of the audit will be		
	•				submitted to the		
	•	n the laboratory			QA Committee for review and		
	calendar.				recommendation		
					Tocommenuation		
					monthly for two months and		
	3.1-35(g)(2)				quarterly thereafter.		
					QA Committee will recommend	d	
					time frame for		
					continued monitoring.		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPL 08/07	ETED		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	E			
ADAMS I	HERITAGE		12011 WHITTERN RD MONROEVILLE, IN 46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	CION .D BE OPRIATE	(X5) COMPLETION DATE		
				5. What date will the sys	stemic_			
					2040			
				completed? August 13, 2	2013.			

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Facility ID: 002549

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/07/2013	
	ROVIDER OR SUPPLIER HERITAGE		12011	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD OEVILLE, IN 46773	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000315 SS=D	BLADDER Based on the resi assessment, the resident who ente indwelling cathete the resident's clin that catheterization resident who is in receives appropri to prevent urinary restore as much re possible. Based on obse record review the ensure cathete the floor for 1 re of 2 residents urinary cathete  Findings include Review of the of Resident #50 of indicated the for included, but we (benign prostat retention, and the Physician's ord dated for the me indicated a Folic catheter.  1. During an ob-	e: clinical record for n 8/7/13 at 8:39 a.m., ollowing: diagnoses ere not limited to, BPH ic hypertrophy), urinary oladder cancer. ers for Resident #50, onth of July, 2013, ey (indwelling urinary)	F000315	It is the policy of this provider ensure that residents' catheter tubing be kept off floor  1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?  Resident care guide for Resid #50 has been updated to include tubing to b kept off the floor.	ent
		ing room on 8/1/13 at		2. How other residents havi	ng

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIJII I	A. BUILDING 00 CO		COMPLETED
		155729	B. WING			08/07/2013
NAME OF I	PROVIDER OR SUPPLIE	D.	<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	ROVIDER OR SUPPLIE	K		12011 V	WHITTERN RD	
ADAMS I	HERITAGE			MONRO	DEVILLE, IN 46773	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		esident #50 was			the potential	
		ed in his wheelchair at			to be affected by the same	
		table. His catheter			deficient practice	
		ended underneath his			-	
		t the catheter tubing			will be identified and what	
	was observed	resting on the floor.			corrective action (s)	
	2 During an o	bservation of the			will be taken?	
	1	I in the dining room on				
		a.m., Resident #50 was				
		·			Other residents having the	
	observed seated in his wheelchair at a dining room table. His catheter bag				potential to be affected by	
		ed underneath his				
	· •	t the catheter tubing			the same deficient practice wi	ill be
		resting on the floor.			identified as those	
	was observed	resulting of the floor.			having indwelling urinary	
	At 0:10 a m	Resident #50 was			catheters. 4 were so	
	· ·	g pushed in his				
		m the dining room to			identified. The Resident Care	
		NA (Certified Nursing			Guide for those	
	1	His catheter tubing			residents were updated to inc	slude
	,	dragging on the floor.			that tubing to be	
	was observed	aragging on the hoor.				
	3 During an o	bservation on 8/6/13 at			kept off the floor. This was completed on August	
	1	esident #50 was			Completed on August	
	· ·	ed in his wheelchair			15, 2013.	
		rsing station. His				
		vas suspended				
		s wheelchair but the			3. What measures will be pu	ut
		g was observed resting			into	<u> </u>
	on the floor.	5 0000. Tod Tooling				
					place or what systemic	
	CNA #3 and C	CNA #4 were			changes will be made	
		n 8/7/13 at 8:50 a.m.			to ensure that the deficient	
		erview they indicated			practice does not	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building		COMPLETED	
		155729	B. WING 08/0			2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-	
		•		WHITTERN RD		
ADAMS I	HERITAGE		MONF	ROEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	) BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	catheter tubing					
	suspended und			<u>recur?</u>		
		ney also indicated the				
	tubing should r	not touch the floor.				
				An audit tool was develope	ed and	
		plan for Resident #50,		DON/designee		
		e of 7/6/12, indicated		will audit catheter tube place	cement	
	•	ea of potential for		on first shift for one	CONTENT	
	complications i	related to use of				
catheter. Approaches to the problem				week, then daily on rotating	g shifts	
	included, but were not limited to,			for one week, then		
secure catheter tubing to leg to avoid				DON/designee will continu	in to	
	pulling or traun	na and ensure		monitor it randomly.	le 10	
	drainage bag is	s off the floor and				
	below bladder	level. The care plan		An in-service will be held of	on	
	did not indicate	e to keep the catheter		August 22, 2013		
	tubing from res	sting on the floor.		which will include the educ	nation	
				recap and	alion	
	A current facilit	ty policy "Catheter				
	(indwelling) car	re and removal", dated		results of the audits to the	staff.	
	2006 from Lipp	oincott Williams &				
	Wilkins and pro	ovided by the DON on				
	8/7/13 a 10:39	a.m., indicated		4. How the corrective act	ion (s)	
	"Intended to	prevent infection		will be monitored to		
		ne drainage bag above				
	bladder level	." The policy did not		ensure the deficient prac	<u>tice</u>	
	indicate to kee	p the catheter tubing		will not recur?		
	from resting or	. •				
				Information gathered from	the	
	3.1-41(a)(2)			audits will		
	, , ,			be forwarded to the QA		
				committee for		
				recommendations and revi	iew	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 08/07/2013		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD				
ADAMS I	HERITAGE			OEVILLE, IN 46773			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	N	
				monthly, for two			
				months, then quarterly there QA Committee will	after.		
				recommend time frame for continued			
				monitoring.			
				5. By what date will the systemic changes be			
				completed? August 15, 20	13.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155729			(X2) MULTIPLE C  A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/07/2013
	ROVIDER OR SUPPLIER		12011	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD COEVILLE, IN 46773	
(X4) ID PREFIX TAG F000329	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
SS=D	DRUG REGIMEN UNNECESSARY Each resident's d from unnecessary drug is any drug with dose (including disexcessive duration monitoring; or with for its use; or in the consequences which should be reduce combinations of the sased on a compresident, the faciliar residents who has drugs are not give antipsychotic drug treat a specific conduction of the sective gradual diseased on intervence gradual diseased on intervence gradual dose repsychotropic manufacture (Resident #56) reviewed for until Findings including Review of the conductated the foliogian intervence in the section of the section	DRUGS rug regimen must be free of drugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate nout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any ne reasons above.  rehensive assessment of a ty must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to ndition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically n an effort to discontinue  view and record lity failed to attempt a eduction for a edication for 1 resident of 10 residents inecessary medication.	F000329	It is the policy of this provider ensure that residents are not given unnecessary medication Further, this provider participa voluntarily in the CMMS direct QIO antipsychotic reduction project nationwide. The providesserts that this resident's car complied with the regulations effect at the time this alleged non-compliance occurred. Present regulations went into effect May 24th, 2013. IDR (informal dispute resolution) is respectfully requested. We se expungement as a remedy.	ns. tes ded ider e in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155729	B. WING 08/07/2013			08/07/2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			WHITTERN RD	
ΔΠΔΜς Ι	HERITAGE				DEVILLE, IN 46773	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	, •	art failure), COPD			What corrective action(s) will be	
	(chronic obstru	ictive pulmonary			accomplished for the resident( found to be affected by the	8)
	disease), HTN	(hypertension),			alleged deficient practice?	
	diabetes mellit	us, dementia,			Resident #56 remains on	
	depression, an	d anxiety.			Seroquel 25 mg q hs (given at	
		•			bedtime) and remains stable w	
	A Nurse's Note	es for Resident #56,			symptoms of paranoia. The	
		indicated she was			physician's order states that do	ose
		fusing to wear O2			reduction is medically	
		•			contraindicated. The attending	
	, , , ,	dered, stating "You are			physician was contacted for do reduction order as a result of t	
	poisoning me v	with this."			finding. He reiterated his previ	-
					order. A request for pharmaci	
		ce Progress Note for			consult on this resident is plac	
	Resident #56,	dated 10/1/12,			and will occur next visit. 2. Ho	ow
	indicated nursi	ng documented on			will the facility identify other	
	9/29/13, she w	as refusing to wear her			residents having the potential	
	O2 and stated	she was being			be affected by the same allege	ed
		e note also indicated			deficient practice and what corrective action will be taken?	,
		npted to redirect the			Other residents with the	•
		everal interventions			propensity to be affected by th	e
					same alleged deficient practice	
		successful. PRN (as			would be identified as those	
	needed) Ativar	•			residents on psychotropic	
	,	5mg. (milligram) was			medications. Eight residents w	/ere
	given.				so identified. The identified	
					residents are included in a	
	A Behavior He	alth			monthly Behavioral Committee meeting, which includes the	†
	Assessment/E	valuation for Resident			Consulting Pharmacist. The	
	#56, dated 10/	3/12, indicated she was			Consulting Pharmacist reviews	3
		evaluation and			the medication regimen and	
	assessment of	her thought process			periodically requests GDR with	nin
		e to periods of anxiety			a timeframe not to exceed six	
		The evaluation also			months. Any recommendation	
i	•	nad begun to refuse			for GDR are subject to approv	
		•			by the attending physician, wh	
	•	ression from the			determines within his scope of	
	evaluation indi	cated her presentation			practice that such GDR is	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155729		8. WING 08/07/2013		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>			WHITTERN RD	
	HERITAGE			MONRO	DEVILLE, IN 46773	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE
		ination of psychomotor			medically appropriate. In addit these residents receive period	
		nd paranoia about her			monitoring for side effects	
		undings plus cognitive			resulting from antipsychotic	
	loss. The impr	ession from the			medication regimen. 3. What	
	evaluation also	indicated a low dose			measures will be put into place	
	of a routine and	tipsychotic like			what systemic changes will be	
	Seroquel 12.5	mg (milligrams) BID			made to ensure that the allege	
	(twice a day) m	night be considered to			deficient practice does not reconstruction The DON(designee) will audit	
	address the pa	ranoia and the belief			those residents on antipsychot	
	staff were pois	oning her.			medication to assure that they	
	,	3			have care planned a GDR if N	ОТ
	A Social Service	ce Progress Note for			medically contraindicated. 4.	
		dated 10/10/12,			How will the corrective actions	be
	•	vas anxious and voiced			monitored to ensure that the	, r.O
	people were la				deficient practice does not reco The DON(designee) will repo	
	l heobie weie ia	ugiling at ner.			the results of the audit to the	
	A Niversala Nieta	o for Decident #EC			QAPI Committee for review an	d
		es for Resident #56,			recommendation monthly for to	
		at 1:30 a.m., indicted			months and quarterly thereafte	
		ented and "afraid of the			QAPI Committee will recomme	end
	•	The note also indicated			time frame for continued monitoring. 5. Date of	
	_	was given and was			completion: August 13, 2013.	
		note further indicated a			, i i i i i i i i i i i i i i i i i i i	
	new order was	received.				
	A physician's s	order for Decident #56				
		order for Resident #56,				
		at 1:30 a.m., indicated				
	·	g every day HS (hour				
	• •	order also indicated to				
	_	dose Seroquel 50 mg				
		en available, then				
	begin HS.					
	A Nurse's Note	es for Resident #56,				
	dated 10/11/12	e at 10:00 p.m.,				
		vas given Seroquel at				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		155729	B. WI			08/07/2013	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
V D V V V C 1	LIEDITACE				VHITTERN RD		
ADAMS I	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFY ING INFORMATION)		TAG	DEFICIENCY)	DATE	_
	5:30 p.m.						
	A Cooled Comile	o Drograda Nota for					
		ce Progress Note for					
		dated 10/11/12,					
		continued to display					
	l •	ontinued to remove he note also indicated					
		ved swearing at family					
		easily agitated.					
	and becoming	easily agitated.					
	A Rehavior Su	mmary for Resident					
		17/12, indicated she					
	l '	episodes of delusional					
		aranoia. The summary					
		she was receiving					
	Seroquel 50 m	•					
		g 110.					
	A facility fax to	the physician of					
	1	dated 10/31/12,					
	· ·	quel 50 mg HS was					
		10/11/12, The fax also					
	l •	ad 2 falls within 1					
		the Seroquel and the					
		s making her very tired					
		g. The fax further					
		the Seroquel be					
		5 mg HS. This					
		on was approved by					
		and the Seroquel was					
		mg HS on 10/31/12.					
		J 112 211 14.0 17 12.					
	Review of the I	Nurse's Notes for					
		dated 11/1/12 through					
		t indicate any further					
		ranoia or delusional					

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i ´			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155729	B. WIN	G		08/07/	2013
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KOVIDEK OK SOTTEIEF				VHITTERN RD		
ADAMS I	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	thinking.						
		nents/Comments for					
	Resident #56,	dated 12/6/12 and					
	12/27/12 indica	ated she only voiced					
	feeling down a	nd having trouble sleep					
	under the moo	d/behavior section.					
	A Request for	Gradual Dose					
	Reduction/Con	traindication for					
	Resident #56,	dated 2/20/13,					
	indicated she w	vas receiving Ativan					
	0.5 mg PRN, S	Seroquel 25 mg HS,					
	Ambien (hypno	otic) 5 mg PRN, and					
	` • •	epressant) 10 mg daily.					
		declined to reduce any					
		on due to: most recent					
		uce medication resulted					
	•	r worsening of resident					
		reduction was likely to					
		dent's function or					
	•	ssed behavior. No					
		mendations were made					
		el, although a reduction					
	on 10/31/12 wa						
	OII 10/31/12 W	นอ อนบบตออเนเ.					
	Review of the I	Nurse's Notes for					
		dated 2/20/13 through					
		indicate any further					
		•					
		ranoia or delusional					
	thinking.						
	Care Dian Elor	ments/Comments for					
		dated 3/14/13, 6/6/13,					
	anu //11/13, ln	ndicated she only					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155729	B. WI	NG		08/07/2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
					VHITTERN RD	
	HERITAGE			MONRO	DEVILLE, IN 46773	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		,		IAG	Dia relative 17	DATE
		down and having g under mood/behavior				
	section.	g under mood/benavior				
	Section.					
	Review of the	clinical record for				
		ndicated there was no				
		by the facility for a				
	· ·	dose reduction) of the				
	, , ,	the reduction on				
	10/31/12.					
	Physician orde	rs for Resident #56,				
	dated for the m	nonth of July, 2013,				
	indicated she r	eceived: Ativan 0.25				
		n 0.25 mg TID (three				
	l ,	RN, Celexa 10 mg				
		equel 25 mg HS for				
	dementia, start	ted 11/1/12.				
		plan for Resident #56,				
		e of December, 2012,				
	indicated the p					
	l ·	de effects related to the				
	use of antipsyo	the problem included,				
	''	nited to, observe				
		tential side effects,				
		n if side effects are				
	1	-pharmacological				
		or anti-psychotics, and				
		eduction will be				
	attempted as s					
	Social Service	staff #2 was				
		8/6/13 at 11:12 a.m.				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  08/07/2013
	PROVIDER OR SUPPLIEF		12011 V	ADDRESS, CITY, STATE, ZIP COI WHITTERN RD DEVILLE, IN 46773	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION
	residents who	rview she indicated receive psychotropic ere reviewed monthly.			
	During the inte was not able to Resident #56's the Seroquel a	8/6/13 at 1:40 p.m.  review she indicated she of determine why sphysician had started at 50 mg daily, instead daily recommended in lealth			
	During the intenursing staff we behaviors in nu Certified Nursing document in the She also indicated documentation #56 since November indicated any incidents of documented for the staff of the staff o	8/7/13 at 1:50 p.m. erview she indicated ere to document ursing notes and ng Assistants were to be care tracker system. eated she could only find of anxiety in Resident ember, 2012. She ed there had not been			
	Drugs", revised provided by the 10:39 a.m., inc	ty policy "Anti-Psychotic d on October, 2011 and e DON on 8/7/13 at dicated "The pordination with the			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/07/2013
	PROVIDER OR SUPPLIER HERITAGE	12011 \	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD DEVILLE, IN 46773	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	Behavior Management team will continually re-evaluate the need for the drug and suggest "drug holidays" or reduction of dosage to the lowest possible dose to control symptoms"			
	3.1-48(a)(2)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIND TETHY	or condition	155729	A. BUILDING		08/07/2013
		100720	B. WING		00/01/2013
	PROVIDER OR SUPPLIER HERITAGE	3	12011	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD ROEVILLE, IN 46773	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F000428 SS=E	IRREGULAR, AC The drug regimer reviewed at least licensed pharmacist r irregularities to th the director of nu must be acted up Based on inter the facility faile recommendation Pharmacist for reviewed for ur	n of each resident must be once a month by a cist.  must report any ne attending physician, and rsing, and these reports oon.  view and record review and to act on the ons of the Consultant 4 of 10 residents	F000428	It is the policy of this provider review and revise any irregularities based on th pharmacist's recommendation report.	
	the clinical reco indicated he was facility on 4/27/ including but no Parkinson's Dis peripheral eder incontinence, so weakness, cell dementia, mon encephalopath disease), histo hypotension, histo	t 10:10 a.m. review of ord for resident #37 as admitted to the /12, his diagnoses ot limited to sease, depression,		1. What corrective action(s) be accomplished  for those residents found to have been affected  by the deficient practice?  Residents #37 & 56 were  started on monthly orthostatic blood pressure checks.  Resident #33 Vitamin D and Calcium were changed  per pharmacy recommendatic Resident #5 is	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/07/2013		
	PROVIDER OR SUPPLIER HERITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE  12011 WHITTERN RD  MONROEVILLE, IN 46773				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
			CROSS-REFERENCED TO THE APPROPRIA	ng nt.		
			3. What measures will be pu	<u>ıt</u>		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155729	A. BUILDING B. WING		08/07/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R		WHITTERN RD		
ADAMS H	HERITAGE			OEVILLE, IN 46773		
		CTA TENTE OF DEPLOYED GIFT		1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	*	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG	REGULATORT OF	R ESC IDENTIF TING INFORMATION)	TAG	into place or what	DATE	
				into place of what		
				systemic changes will be ma	ade_	
				to ensure that the		
				deficient practice does not		
				<u>recur?</u>		
				A system has been developed	d to	
				assure the		
				recommendations are reviewe		
				monthly.	eu	
				monany.		
				Pharmacist's report will be ser	nt to	
				DON/Designee.		
				DON/Designee will distribute t	the	
				recommendations		
				to the appropriate physician.		
				DON/Designee will		
				monitor/audit monthly for retui	rn	
				response and		
				accuracy of order.		
				4. How the corrective action	<u>)(s)</u>	
				will be monitored		
				to ensure the deficient pract	ice	
				will not recur?		
				Result of the audit will be		
				submitted to the		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	(X2) MULTIPLI A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/07/2013		
	ROVIDER OR SUPPLIER HERITAGE		STREET ADDRESS, CITY, STATE, ZIP CODE  12011 WHITTERN RD  MONROEVILLE, IN 46773				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION		
				QA Committee for review a recommendation	and		
				monthly for two months an quarterly thereafter.	d		
				QA Committee will recommitime frame for	nend		
				continued monitoring.			
				5. What date will the sys	temic_		
				completed? August 13, 2	013.		
	the clinical reco indicated she w facility on 8/6/0 including but no	2:45 p.m. review of ord for resident #33 vas admitted to the 8 with diagnoses of limited to congestive rial fibrillation, and					
	Physician/Pres	ote to Attending criber" which came acy, dated 3/20/13, ollowing:					
	D 50,000 BID ( weeks and also	was started on Vitamin two times daily) x 12 o Vitamin D 5,000 IU o due to a level of 14					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLE	
		155729	B. WIN	IG		08/07/2	013
NAME OF P	ROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VHITTERN RD		
ADAMS F	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	•	er the Vitamin D 5,000					
		ed and the facility is					
		out of pocket for this					
	_	sider changing her to					
	this alternative:						
		D = 000 H   C = - :					
	•	n D 5,000 IU QD and					
	, ,	r to Vitamin D 50,000					
	IU Q (every) w	eek.					
		. 500 DID (					
	2. Change Calcium 500 mg BID to						
	Calcium+D 600	0/400 IU BID.					
	Dovious of a "N	ata ta attandina					
		ote to attending					
	_	criber" which came					
	-	nacy with a date of					
	5/10/13 indicat	ed the following:					
	"Decident #33	is on Vitamin D 5000					
		cium 500 mg BID. She					
		e medications. Could					
	_	to Vitamin D 50,000					
		d Calcium+D 600/400					
	_	ner supply is exhausted					
	to provide daily						
		on and also to try and					
	uecrease medi	cation burden a bit?					
	On 8/5/12 at 2:	00 n m. review of					
		00 p.m. review of					
		physician orders					
		vas still receiving					
		every day, and					
	Caicium 500 m	illigrams twice daily.					
	3. A review of	Resident #5's clinical					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	A. BUILI	DING	NSTRUCTION  00	(X3) DATE : COMPL 08/07/	ETED
	PROVIDER OR SUPPLIEF	<u> </u>	B. WING	STREET A 12011 W	DDRESS, CITY, STATE, ZIP CODE VHITTERN RD DEVILLE, IN 46773		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	a.m., indicated but were not lin vascular attack anemia, atrial thypertension, of thrombocytope tremors and de	depression, enia, anxiety, dyspnea, ehydration.					
	indicated Residual ordered every metabolic panel blood count (C pharmacist indicates were do since the residual ordered every metabolic panel pharmacist indicates were do since the residual ordered every metabolic pharmacist indicates were do since the residual panel pa	harmacist on dated 2-14-2013, dent #5 had labs 3 months for a basic el (BMP) and complete eBC). The consultant icated last laboratory one in August 2012 and ent was off hospice to os were completed.					
		recapitulation ratory orders for a BMP be completed every 3					
	Resident #5's of a CBC and BM 2-26-2013 and on 5-14-2013. Iaboratory resurecommended 4. Review of the Resident #56 of	oratory results in clinical record indicated IP were completed on a BMP was completed There were no ults for a CBC as /ordered for May 2013. The clinical record for the son 8/5/13 at 10:13 a.m., collowing: diagnoses					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING (COMPLET CONSTRUCTION (COMPLET COMPLET			ETED		
		155729	B. WIN	G		08/07/	2013
NAME OF P	ROVIDER OR SUPPLIEF			12011 V	ADDRESS, CITY, STATE, ZIP CODE VHITTERN RD		
ADAMS I	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	(congestive he (chronic obstru disease), HTN	vere not limited to, CHF art failure), COPD active pulmonary (hypertension), us, dementia, anxiety, n.					
	#56, dated 10/3 consider a rout	alth valuation for Resident 3/12, indicated to tine antipsychotic like dress the paranoia.					
	A physician's order for Resident #56, dated 10/11/12, indicated Seroquel 50 mg (milligrams) every day at HS (hour of sleep).						
	Regimen Reviet dated 3/19/13, Seroquel and to commonly cauthypotension as also recommentated at laying standing blood consecutively a MAR (Medication of the date	s a result. The review nded a monthly nursing , then sitting, then					
	#56 for the mo April, 2013, Ma	MAR's for Resident nths of March, 2013, ay, 2013, June, 2013, d August, 2013,did not					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	CON	TE SURVEY  MPLETED
		155729	B. WING	_	08/	07/2013
	PROVIDER OR SUPPLIEI HERITAGE	3	12011 V	ADDRESS, CITY, STATE, ZIP CO WHITTERN RD DEVILLE, IN 46773	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Static blood pressures	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(Director of Nu p.m., indicated Recommendat for orthostatic followed by nu Resident #37 or pressure by ta pressures laying LPN #1 was in 10:42 a.m. Du indicated only were taken on also indicated	terviewed on 8/7/13 at uring the interview she weekly blood pressures Resident #56. She orthostatic blood				
	the Director of did not know was getting the pharecommendation and returned to the disconnection of the disconnection of the disconnection of the pharecommendation of the	0:40 a.m. interview with Nursing indicated she what the system was for armacy ons to the physicians				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155729	B. WIN			08/07/2013	
			J. ,, 1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			WHITTERN RD		
ADAMS I	HERITAGE				DEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	faxed forms, a	nd when she gets the					
	returned fax from the physician she places it in the clinical record.  During an interview with the Director						
	of Nursing (DON) on 8-6-2013 at 9:31						
	,	indicated the lab					
	•						
		CBC from the physician					
	•	for April 2013 were not					
	entered in the laboratory book and						
	the CBC was r	not done.					
	~	view with the Medical					
	Records Staff	#6 on 8-7-2013 at 8:40					
	a.m., the Medi	cal Records Staff #6					
	indicated she	did not receive a copy					
	of the Consulta	ant Pharmacist's					
		gimen Review dated					
		ch recommended labs					
		BMP every 3 months.					
		•					
		she did not know to					
	•	and BMP on the lab					
	calendar.						
		:30 a.m., the DON					
	provided the fa	acility policy titled, Drug					
	Regimen Revie	ew, with date revised:					
	04/10, indicate	d, "The Consultant					
		views the medication					
		ch resident at least					
	monthly. Findi						
	_	ons are reported to the					
		•					
		Director of Nursing, the					
	responsible Ph	nysician and the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPL	ETED		
		155729	B. WIN			08/07/	2013	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
ADAMS I	HERITAGE		12011 WHITTERN RD MONROEVILLE, IN 46773					
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	Medical Directo	•						
	appropriateT							
		cuments all potential or						
	_	nt pharmaceutical						
		problems found						
	relating to med							
		them to the DON						
	through Pharm							
	Reviewthe re	•						
		n the Consultant						
		iew record or in the						
		cal recordthe						
		armacist utilizes						
		ated standards of care,						
	in addition to of	ther applicable						
	standards"							
	3.1-25(i)							
			1				<u> </u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET		COMPLETED	
		155729	B. WING		08/07/2013	
				T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1				
ADAME L	HERITAGE		12011 WHITTERN RD MONROEVILLE, IN 46773			
ADAMS I	IERITAGE		IVIOIN	ROEVILLE, IN 40773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F000514	483.75(I)(1)					
SS=E	RES					
		PLETE/ACCURATE/ACCE				
	SSIBLE					
	•	maintain clinical records on				
		accordance with accepted				
	professional standards and practices that are complete; accurately documented; readily accessible; and systematically					
	organized.	e, and systematically				
	organizou.					
	The clinical record	d must contain sufficient				
	information to ide	ntify the resident; a record				
		assessments; the plan of				
	care and services	s provided; the results of				
	any preadmission	screening conducted by				
	the State; and pro	ogress notes.				
	Based on inter-	view and record	F000514		08/16/2013	
	review, the faci	ility failed to follow their		It is the policy of this provider	to	
		cedure for ensuring		ensure that the		
		ress notes were				
		clinical record for 9 of		documentation in clinical recor	rds	
				is accurate and		
		ecords reviewed.		complete.		
	•	5, #26, #37, #43, #44, #		Complete.		
	51, #52, # 60, #	#64)				
	Findings includ	le:		1. What corrective action(s)	will	
				be accomplished	-	
	1. A review of	the clinical record for				
		on 8/5/13 at 10:10		for the resident(s) found to b	<u>e</u>	
	a.m., indicated			affected by the		
	•	•				
	•	uded but were not		alleged deficient practice?		
	•	inson's Disease,				
		ripheral edema, urinary				
		sleep apnea, fatigue,		All Residents whose charts we	are	
	weakness, cell	ulitis, dermatitis,		lacking physician	,,,	
	dementia, mon	oneuritis, neuropathy,				
		y, CKD (chronic kidney		progress notes have had the		
	3espiiaiopatii	,, 5.12 (5.115 Harris)		1. •		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155729	B. WIN			08/07/	2013
		1	D. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹					
VDVMC	HERITAGE		12011 WHITTERN RD MONROEVILLE, IN 46773				
ADAMO	ILITIAGE			MOM	3EVILLE, IN 40773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COR			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	disease), histo	ry of falls, orthostatic			progress notes signed		
	hypotension, herniated disc, history of prostate cancer, history of head trauma, acute confusional state, brain						
					by the physician and placed o	n	
					the respective chart.		
	disease.	comasional state, brain					
	uisease.						
					2. How will the facility identity	fv	
		e Doctor's Progress			other residents having	<u>y</u>	
	Notes for Resi	dent #37 indicated he			<u>other residents having</u>		
	was seen by th	ne Nurse Practitioner on			the potential to be affected b	V	
	7/17/13.				the same alleged		
	The clinical record for Resident #37				deficient practice and what		
	did not contain				corrective action will be		
	•	progress notes from the			taken?		
	visit on 7/17/13	3.					
					Residents with the propensity	to	
	<ol><li>Review of th</li></ol>	ne clinical record for			be affected by the	lo	
	Resident # 60	on 8/5/13 at 2:50 p.m.,			be affected by the		
		ollowing diagnoses			same alleged deficient practic	e	
		ot limited to, COPD			would be identified as		
		•					
	•	ictive pulmonary			those whose attending physici	an	
	· · · · · · · · · · · · · · · · · · ·	entia of Alzheimer's			was a specific		
	, ·	nood, hypothyroidism,					
	HTN (hyperter	ision), hyperlipidemia,			physician. Said charts were		
	fracture of C2	vertebra, generalized			audited and residents		
	pain, GERD (d	astroesophageal reflux			l		
		mnia, nausea, anemia,			whose charts were lacking		
	migraine head				physician progress notes		
	i ingranie neau	aonos.			have had the progress notes		
		N. 6			signed by the physician		
		gress Notes for			Signed by the physician		
		ndicated she was seen			and placed on the respective		
	by the Physicia	an on 7/3/13.			chart.		
	-						
	The Physician	Progress Notes for the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE			COMPLETED
		155729	B. WIN			08/07/2013
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R			WHITTERN RD	
ADAMS I	HERITAGE				OEVILLE, IN 46773	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Physician visit	on 7/3/13 was not				
	present on Res	sident #60's clinical			3. What measures will be pu	<u>t</u>
	record.				into place or what	
					avatamia abangsa will be me	. da
					systemic changes will be ma to ensure that the	ide_
	3 A review of	the clinical record for			to ensure that the	
		on 8/6/2013 at 11:30			alleged deficient practice do	es
					not recur?	
	a.m., indicated	•				
		uded but were not				
	I	neimer's Disease,				
	depression, D	M II (diabetes mellitus			The Medical Records designe	e
	type II), CVA (cerebral vascular				will audit for	
	accident or a s	stroke), CAD (coronary			physician's progress notes 72	
	artery disease	), HTN (hypertension),			hours (410AC16.2-	
	COPD (chroni				110013 (410/1010.2	
	pulmonary dise				3.1-22(c)(2)) after each	
	l ·	nyperlipidemia, history			physicians' visit. The results	
	• •	• • • • • • • • • • • • • • • • • • • •				
		cture with repair,			of the audits will be	
	,	nyocardial infarct or			communicated to Director of	
	heart attack).				Nursing.	
					The Director of Nursing or	
	A review of the	e Doctor's Progress			The Director of Nursing or designee	
	Notes for Resi	dent #26 indicated he				
	was seen by th	ne Physician on 7/3/13.			will immediately ensure the iss	sue
					is addressed and	
	The Physician	Progress Notes for the				
	1	on 7/3/13 was not			corrected and that the residen	t's
	1 -	sident #26's clinical			care remains	
	record.				modically appreciate	
	i icolu.				medically appropriate.	
		the clinical record for			4. How will the corrective	
	Resident #43 o	on 8/6/2013 at 1:45			actions be monitored to	
	p.m., indicated	I the following				
	diagnoses incl	uded but were not			ensure that the deficient	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLET	TED
		155729	B. WIN			08/07/20	013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	WHITTERN RD		
ADAMS HERITAGE					DEVILLE, IN 46773		
ADAMO	ILITIAGE			WONK			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	limited to, CAD	(coronary artery			practice does not recur?		
	disease), DM I	I (diabetes mellitus					
	type II), HTN (I	nypertension),					
	peripheral neu	ropathy, dementia,			The DON will bring the results	of	
	• •	che, hyperlipidemia,			the audits to the	01	
	_	n,actinic karatosis,					
	• • •	men, otitis media, ear			monthly QA&A/PI Committee		
	· •	men, ouus media, ear			meeting for review and		
	pain.						
	A massiass of the	Destaria Dragrasa			recommendations. The QA&A	VPI	
		e Doctor's Progress			Committee will		
		dent #43 indicated she					
	•	ne Nurse Practitioner on			communicate to the Adams Health Network's Chief of		
	7/17/13.				Health Network's Chief of		
					Medical Staff and the Board of	f	
	The Nurse Pra	ctitiioner's Progress			Directors, any		
	Notes for the v	risit on 7/17/13 was not					
	present on Res	sident #43's clinical			patterned non-compliance and	i l	
	record.				they shall determine		
	100014.						
					sanctions. At that time, they w	/III	
	E A rovious of	the clinical record for			determine the		
		the clinical record for			continued frequency of audit.		
		on 8/7/2013 at 8:40			continued irequency of addit.		
	a.m., indicated	•					
	diagnoses incl	uded but were not					
	limited to, dem	entia, HTN			5. Date of Compliance:		
	(hypertension)	, depression, anxiety,			08.16.2013		
		ness, constipation,					
	· ·	history of UTI (urinary					
		history of right hip					
	fracture with re	:paii.					
		D 1 1 D					
		Doctor's Progress					
		dent #52 indicated he					
	was seen by th	ne Physician on 7/3/13.					
					<u> </u>		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155729	B. WIN	G		08/07	/2013
NAME OF F	PROVIDER OR SUPPLIEF	3	_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					VHITTERN RD		
ADAMS HERITAGE				MONRO	DEVILLE, IN 46773		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO		ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Physician	Progress Notes for the					
	Physician visit	on 7/3/13 was not					
	present on Res	sident #52's clinical					
	record.						
	6. On 8/5/13 at	t 2:00 p.m. review of					
	the clinical rec	ord for resident #51					
	indicated she v	vas admitted to the					
	facility on 6/18	3/11 with diagnosis					
	including but n	ot limited to cataracts,					
	congestive hea	art failure, osteoporosis					
	and cancer of the colon.						
	Review of the	clinical record indicated					
	the Nurse Prac	ctitioner had visited the					
	resident on 7/1	9/13 and documented					
	that the physic	ian notes were					
	1	ere were no notes in					
	•	he 7/19/13 visit.					
	7. Review of th	ne clinical record for					
		on 8/6/13 at 8:46 a.m.,					
		ollowing: diagnoses					
		vere not limited to,					
	dementia, depi						
		, hypothyroid, abnormal					
	l ` • · · · · · · · · · · · · · · · ·	on, wheezing, prostate					
	CA, and urinar	• .					
	ort, and anna	, rotoridori.					
	A Doctor's Pro	gress Notes for					
		ndicated he was seen					
		an/Nurse Practitioner					
	on 6/12/12 and						
	011 0/12/12 all						
	Review of the	clinical record for					
	Resident #64 I	ndicated there was no					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 08/07/2013					
	155729			G		08/07/	2013	
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE			
ADAMS HERITAGE					WHITTERN RD DEVILLE, IN 46773			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE PROPERTIES OF TH		TE COMPLETION DATE		
TAG		Physician/Nurse		TAG			DATE	
		7/7/13 in the clinical						
	Resident #25 of a.m., indicated but were not ling failure, chronic IV, acute kidner fibrillation, condiabetes, hyperhypothyroidism metabolic ence							
	Notes page in record indicate the nurse prace 7-19-2013. The nurse prace were not in recovisit.	e Physician Progress the Resident #25's ed a signature only from titioner visit on ctitioner progress notes cord from the 7-19-2013 ent progress note in the						
	clinical record	for Resident #25 was ractitioner visit from						
	Resident #44 of p.m., indicated	the clinical record for on 8-5-2013 at 2:39 diagnoses included mited to dementia,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
	I 155729 ■		A. BUI B. WIN			08/07/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					WHITTERN RD		
ADAMS HERITAGE					DEVILLE, IN 46773		
ADAMO	ILITIAGE			WONK	JEVIELE, IIV 40773		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	history of falls,	cataracts,					
	hypertension, of	chronic obstructive					
	pulmonary dise	ease, anemia,					
	confusion, atria	al fibrillation and					
	transient ische						
	Δ review of the	Physician Progress					
		the Resident #44's					
		ed a signature only from					
	the nurse pract	titioner visit on					
	7-19-2013.						
	•	ctitioner progress notes					
	were not in rec	ord from the 7-19-2013					
	visit.						
	The most rece	nt progress note in the					
		for Resident #44's					
		the nurse practitioner					
	visit from 5-7-2	·					
	VISIL 110111 3-1-2	.013.					
		ith the Medical Records					
		-2013 at 8:38 a.m.,					
	indicated the p	hysician's office was					
	notified on 8-6-	-2013 about the					
	missing progress notes for the						
	• • •	ed from July 2013. The					
		ds staff #6 indicated					
	the progress notes from the nurse						
	•	isits were usually					
	received 3 to 4 weeks after the nurse						
	practitioner vis	it.					
	During an inter	view with Medical					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL		
MOLLAN	or connection	155729		LDING		08/07/	
		.00,20	B. WIN		DDDECC CITY CTATE ZID CODE	33/31/	
NAME OF P	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE  VHITTERN RD		
ADAMS HERITAGE					DEVILLE, IN 46773		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		3/7/13 at 2:35 p.m.,	_	TAU			DATE
		hysician progress					
		/13 were brought to the					
		nd also indicated the					
		se Practitioner progress					
	notes for 7/17/						
	available.	•					
	_	v of the current policy					
	•	rvices" dated 7/11 and					
		e Director of Nursing on					
		30 a.m., the policy					
		the option of the					
		iired visitsmay					
		een personal visits by					
		and visits by anurse  A progress note will					
	•	signed/dated by the					
	physician at the	-					
		notes must be filed in					
		ord within 72 hours or 3					
	business days						
	ĺ						
	3.1-50(f)(5)						

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		IDENTIFICATION NUMBER:  155729	A. BUILDING	00	COMI	e survey Pleted 7/2013		
	PROVIDER OR SUPPLIER		B. WING OB/07/2013  STREET ADDRESS, CITY, STATE, ZIP CODE  12011 WHITTERN RD  MONROEVILLE, IN 46773					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE		

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